STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155446	A. BUILDING 01 B. WING	10/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVINGTON MANOR HEALTH AND REHABILITATION CENTER	5700 WILKIE DR FORT WAYNE, IN 46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Quality Assurance Walk-thru Survey was conducted by the Indiana State Department of Health. Survey Date: 10/31/12 Facility Number: 000476 Provider Number: 155446 AIM Number: 100290870 Surveyor: Amy Kelley, Life Safety Code Specialist At this Quality Assurance Walk-thru survey, Covington Manor Health and Rehabilitation Center was found not in compliance with 410 IAC 16.2-3.1-19(ff). This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridors and battery operated smoke detectors in the resident rooms. The facility has a capacity of 149 and had a census	K0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a desk review certification of compliance on or after 11/30/2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	of 134 at the time of this survey. The facility was found not in compliance with state law in regard to sprinkler coverage but was found in compliance with state law in regard to smoke detector coverage. All areas where the residents have customary access were sprinklered, except the overhangs at the following exits; West Wing 100 hall, West Wing 200 hall, Bed and Breakfast Wing and the East Wing 300 hall. All areas providing facility services were sprinklered, except a shed used for general storage and a garage used for maintenance storage. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/02/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K9999	State Findings 3.1-19 ENVIRONMENT AND PHYSICAL STANDARDS 3.1-19(ff) A health facility licensed under 16-28 and this rule must do the following: (1) Have an automatic sprinkler system installed throughout the facility before July 1, 2012. (2) If an automatic sprinkler system is not installed throughout the health care facility before July 1, 2010, submit before July 1, 2010 a plan to the department for completing the installation of the automatic sprinkler system before July 1, 2012. (3) Have a battery operated or hard-wired smoke detector in each resident's room before July 1, 2012. This State Rule has not been met as evidenced by: Based on observation and interview, the facility failed to have a complete automatic sprinkler system installed throughout the facility before July	K9999	**K9999 -** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** It is the practice of this facility to have an automatic sprinkler system installed throughout the facility. The 108 residents that reside on the East and West wings were not affected by this alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:** No residents or employees were identified to be affected by this alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** All residents and employees have the potential to be affected by this alleged deficient practice. The identified exit overhangs on the East and West Wings will have an automatic sprinkler head installed. The facility approved a quote on 11/13/2012. The vendor requires 7 to 10 business days for shipping of needed parts. The vendor will then coordinator with the facility's Maintenance Director to perform the necessary repairs. The proposed quote is attached to this Plan of	11/30/2012

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	1, 2012. This deficient practice could affect 108 residents in the East and West Wings. Findings include: Based on observation with the Maintenance Director on 10/31/12 from 1:04 p.m. to 2:00 p.m., the following exit overhangs measured four foot three inches; the West Wing 100 hall and 200 hall, the Bed and Breakfast Wing and the East Wing 300 hall. Measurements were provided by the Maintenance Director at the time of observations. The overhangs appeared to be made of combustible material. Based on an interview with the Maintenance Director at the time of observations, he confirmed the overhangs were made of wood. 3.1-19(ff)		Correction. The estimated completion date is 11/30/2012. A facility audit was conducted by the facility Maintenance Director to ensure overhangs were compliant with the alleged deficient practice. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur ie., what quality assurance program will be put into place:** The Maintenance Director completed a facility audit of all sprinkler heads to ensure facility wide compliance. Findings were reported to the Executive Director for follow and review. **By what date the systemic changes will be completed:** Compliance Date = 11/30/2012	